

Do Not Attempt Resuscitation (DNAR) Decisions: A Discussion

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Abstract

Resuscitation discussions are an important aspect of patient care. Discussions need to be approached sensitively, while ensuring the overall best interest of the patient remains central. Patients may hold different opinions regarding resuscitation that can be influenced by a number of factors. Resuscitation decisions lie with the healthcare provider however it is important for patient preference to be considered and vital for a decision to be communicated to the patient in question once it has been reached. When clinicians feel enabled and confident in their ability have honest, open and sensitive conversations with patients regarding resuscitation status, these important discussions can be normalised, ensuring ongoing care is in line with a patient's best interests and their wishes.

Article

Advance care planning and discussions surrounding resuscitation are an important consideration in the care of any patient. As healthcare professionals, we are caring for an aging and increasingly medically complex cohort of patients. It is important to consider the appropriateness of CPR in the care of any patient felt to be at risk of cardiopulmonary arrest. Addressing these issues with the patient and their loved ones requires open, sincere and thoughtful conversation, tailored to the patient's clinical needs and personal preferences¹. As clinicians entrusted with the care of our patients, we have the responsibility to ensure that we do not offer or provide an intervention that may cause harm to our patient without any discernible benefit. Exploring these topics and holding conversations with patients and their loved ones can be challenging for physicians.

During the height of the COVID-19 pandemic, the importance of resuscitation discussions was intensified due to the focus on pragmatic use of resources in the face of an expectantly stretched health system^{1,2}. HSE guidance on decision-making during the COVID-19 pandemic described advance care planning as "having honest, open and sensitive discussions with people about their

condition and prognosis in a language that they can understand, eliciting their goals and preferences, and making decisions having regard to their wishes about what interventions would be appropriate if there were a deterioration in the person's condition"¹.

To normalise resuscitation discussions, we need to incorporate them into routine practice during hospital admission³. Asking a simple question such as "Have you ever had a conversation with your doctor or family as to what to do in an emergency?" or "what would you want if your health was declining?", could open the conversation. There are several prompts that may cause a clinician to consider their patient's resuscitation status. These may include a patient wishing to discuss their resuscitation status, the presence of a life limiting illness, a noted significant decline in health, a considerable chance the patient may die in the next year or if there is felt to be unrealistic expectations from the patient or their loved ones¹. This process may highlight four different patient groups to the clinician; patients who would likely survive CPR but have strong, consistent preferences against CPR, patients who have an established and documented preference to limit resuscitative measures, patients who are stable but have a life-limiting or progressive condition, with a considerable chance of dying within the year, and finally patients is those whose disease trajectory has come to the point where CPR will not restore life and a cardiac arrest would be an irreversible, terminal event.

Clinicians are not legally obligated to offer or provide an intervention which is not in a patient's best interests, despite their wishes. However, DNAR discussions with patients and families have changed since the "Tracey V Cambridge University NHS Foundation Trust (2014)" case^{2,4,5}. A DNAR order has the potential to deprive persons of a life-saving treatment. Thus, if clinicians believe resuscitation is futile, there is an obligation for patients to be informed of such decisions, unless it is deemed likely to cause significant physical or psychological harm. Distress is not an adequate reason for not involving the patient in the decision-making process. The duty to disclose ensures an opportunity for a patient to obtain a second opinion. Failure to disclose a DNAR decision could be deemed a breach of Article 8 of the European Convention of Human Rights⁵. Although this initial ruling did not take place in Ireland, such a ruling would also apply here¹.

The manner in which we approach resuscitation discussions as clinicians can vary widely and greatly impact on patient understanding of the topic⁶. It is important to avoid medical jargon and ambiguity. Frame the conversation to meet the patient's personal goals; discuss what functionally is a good day for them, what is important to them, what brings them joy, and what gives them strength. The patient needs to know what their expected prognosis would be if treatment goes well and if treatment does not achieve what is wanted. Resuscitation may not be realistic option and it is the clinician's obligation to convey this to the patient¹.

Checking patient understanding of CPR is of critical importance. Patients and families may have unrealistic views about the success rate and implications of CPR that need to be addressed in a frank but sensitive manner appropriate for the clinical situation and patient. Communicating a DNAR decision by exploring the severity of their illness and explaining how CPR may not achieve what is important to them may help indicate the decision-making process. It should be emphasised what treatments and interventions will be available to the patient, so they do not mistakenly consider a DNAR order to mean a complete lack of treatment, medical intervention or care.

The language used among clinicians and in discussion with patients is important. The term “ceiling of care” can be used to reference medical interventions that a patient may be offered. This may be misleading, suggesting to patients that their care will be somehow deficient. We can care to the highest level for our patients irrespective of medical interventions on offer. It may be more appropriate to talk about “goals of care”, to suggest that care is a continuous, integral part of their management and that what we are trying to achieve may not always equate to longevity at the detriment of comfort but instead to the quality of the time remaining.

Normalising the natural dying process and discussions around resuscitation with our patients can be built into daily clinical practice, helping our patients understand what can be realistically achieved medically in advancing, non-curable disease. This allows focus to move towards goals that lie outside the hospital with family, friends, and loved ones. Having these conversations can be challenging for clinicians, however, they can be the most rewarding. Patients want our advice and honesty. Priorities often change with an understanding of prognosis and the reality of imminent mortality comes into sharper focus.

It is important to ensure that resuscitation decisions are not framed as a decision that the patient or loved ones need to make themselves³. This can cause stress to patients or loved ones who may not be aware that resuscitation can be withheld if it is deemed futile. Some patients or family members may feel under duress to be seen as “doing everything they can”. It may alleviate distress that can accompany such discussions if the patient or family know that although their wishes and preferences will be regarded highly in reaching a decision, the decision lies with the treating clinician. In attempting to acknowledge and respect patients’ wishes we must remember we have a responsibility not to offer what we cannot in good faith deliver, and above all, do no harm.

Missed opportunities for resuscitation conversations can lead to unnecessary medicalisation of the natural dying process, obstructing an important phase of a patient’s life that could be spent surrounded by loved ones in comfort and dignity in their preferred place of care. Advocating for our patients’ best interests at end of life gives them the opportunity to focus on what is important to them.

The “Think Ahead” document, formulated by the Irish Hospice Foundation, is a helpful tool that patients can utilise to assist in advanced care planning, allowing them to record their wishes and preferences regarding care⁷. It is important to encourage patients to consider using such tools when appropriate and to consider local protocol to ensure the adequate documentation of resuscitation status after the decision has been made and discussed.

The impact of conversations regarding advance care planning and resuscitation cannot be understated, but it is not without its challenges. It is important to approach these conversations in a manner that is patient-centred, addressing patient-needs and wishes. Normalisation of the dying process avoids unnecessary medicalisation and intervention towards the end of a person’s life, allowing space for comfort and dignity.

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